

DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare
6700B Rockledge Drive, Suite 2500, MSC 6910
Bethesda, Maryland 20892-6910
Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare
6700B Rockledge Drive, Suite 2500
Bethesda, Maryland 20817
Telephone: (301) 496-7163
Facsimile: (301) 402-7065

May 17, 2019

Re: Animal Welfare Assurance #A3290-01 (OLAW Case 1U)

Dr. Todd Evans Associate Dean for Research Weill Cornell Medical College 1300 York Avenue, LC710 New York, NY 10065

Dear Dr. Evans,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your May 16, 2019 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at Weill Cornell Medical College. According to the information provided, OLAW understands that mice on a radiation study became moribund or died but were not identified by the animal caretaker during the daily health check. The irradiation procedure was not listed on the protocol and the mice had not been transferred to the protocol which describes the procedure.

The corrective actions consisted of checking all cages for additional affected mice but none were found. The animal caretaker involved was retrained on conducting health checks, disciplined, and scheduled for additional training on animal care and welfare. A trainer will assess the caretaker's understanding of procedures. The veterinarian will determine if the expected morbidity/mortality is able to be reduced and whether the observation schedule needs to be enhanced. The Principal Investigator and staff were counseled and the protocol was amended to include the irradiation.

Based on its assessment of this explanation, OLAW understands that measures have been implemented to correct and prevent recurrence of this problem. OLAW concurs with the actions taken by the institution to comply with the PHS Policy.

Sincerely,

(b) (6)

Axel Wolff, M.S., D.V.M.
Deputy Director
Office of Laboratory Animal Welfare

cc: IACUC Chair

Institutional Animal Care and Use Committee 1300 York Avenue, Box 5 New York, NY 10065

Telephone: 646-962-2981/2 Email: iacucadmin@med.comell.edu

445 East 69 Street, Olin Hall Rm-423 New York, NY 10065

May 16, 2019

Brent Morse, DVM
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Re: Assurance # D16-00186

Dear Dr. Morse:

We are writing to report an incident of non-compliance that occurred within the animal care and use program at Weill Cornell Medicine. The incident was presented to and discussed by the IACUC during the month of May. The incident and resolution is as follows:

Several cages containing moribund and dead mice were observed during a regulatory inspection. The Animal Care Technician (ACT) responsible for the housing room had completed their morning animal health checks in the room earlier in the day, and had failed to identify the affected mice. The room was immediately rechecked, and no further unhealthy animals were identified. The ACT was retrained on animal health check procedures, issued disciplinary action for a failure to perform their duties, and was scheduled for a training session emphasizing animal care and welfare. The ACT will also complete a practicum next month during which a trainer will reassess his understanding of procedures. (These experiments are not PHS funded.)

All of the mice had been irradiated as described in the protocol, and while radiation-induced sickness and mortality was identified as a potential outcome, the veterinarian supporting the facility will determine the cause of the morbidity and the mortality and whether it is preventable or reducible. They will also assess whether the current animal observation schedule is adequate to identify animals with declining health at an earlier stage.

In addition, it was determined that the irradiation procedure was not described in the protocol. The animal user was listed as personnel on another PI's protocol on which the procedure was described. These animals should have been transferred to that protocol prior to irradiation. Both PI's were contacted by the IACUC and the procedure will be added to

the protocol under which the animals were purchased. The IACUC Chair will meet with the PI and his lab to discuss these concerns and how to prevent them going forward.

We believe that these issues have been adequately addressed and that the procedures implemented should prevent recurrence. Should you have any questions or concerns, please contact me at (b) (6) or the IACUC Chairman, Dr. Andrew Nicholson, at (b) (6)

Sincerely,

(b) (6)

Todd R. Evans, Ph.D.
Institutional Official
Associate Dean for Research
Weill Cornell Medicine

Wolff, Axel (NIH/OD) [E]

From:

Sent:

Friday, May 17, 2019 6:55 AM

To:

(b) (6)

Cc:

OLAW Division of Compliance Oversight (NIH/OD)

Subject:

OLAW Division of Compliance Oversight (NIH/OD)

RE: WCM IACUC Incident Report (#D16-00186)

Thank you for this report, (b) (6)

We will send a response soon.

Axel Wolff, M.S., D.V.M.

From:(b) (6)

Sent: Thursday, May 16, 2019 4:55 PM

To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>

Cc: Andrew C. Nicholson <nicholso@med.cornell.edu>; Todd R. Evans <tre2003@med.cornell.edu>

Subject: WCM IACUC Incident Report (#D16-00186)

Importance: High

Deputy Director, OLAW

Dear OLAW:

Please find a WCM IACUC incident report attached and let me know if any further clarifications are required.

Best regards,



